Arizona Medical Board

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DRAFT MINUTES FOR REGULAR SESSION MEETING
Held on December 13, 2007 and December 14, 2007
9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

William R. Martin III, M.D., Chair
Douglas D. Lee, M.D., Vice Chair
Dona Pardo, Ph.D., R.N., Secretary
Dan Eckstrom
Robert P. Goldfarb, M.D., F.A.C.S.
Patricia R. J. Griffen
Ram R. Krishna, M.D.
Todd A. Lefkowitz, M.D.
Lorraine L. Mackstaller, M.D.
Paul M. Petelin Sr., M.D.
Germaine Proulx
Amy J. Schneider, M.D., F.A.C.O.G.

Call to Order
The meeting was called to order at 9:30 a.m.

Roll Call
The following Board Members were present: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was not present: Mr. Eckstrom.

Agency Report
Amanda J. Diehl, Deputy Executive Director, informed the Board that the State may sweep $567,000 from the Board's reserve funds. She said the Board is to keep a six month reserve fund and if the State were to take $567,000 that would leave the agency with only three months in reserve. She stated the Board's Legislative Liaison, Stuart Goodman, is doing a wonderful job in opposing the request and that she will advise the Board of any developments.

Consideration and Approval of Office Based Surgery Rules
Dr. Martin presented the Board with the proposed change to the Office Based Surgery Rules. He said the Office Based Surgery Subcommittee previously met with stakeholders, staff and legal counsel. One amendment was made to the Rules, which was an addition of "health care professional." He stated the stakeholders were in agreement with the proposed language and asked the Board to approve the Rules as amended.

MOTION: Ms. Proulx moved to approve the Office Based Surgery Rules as amended.
SECONDED: Ms. Griffen
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Krishna expressed his appreciation for the Subcommittee's hard work and the public's participation in developing the guidelines. Dr. Martin thanked Drs. Goldfarb and Lee for serving on the Subcommittee. Dr. Martin also thanked Ms. Diehl, Ms. McGrane and Mr. Goodwin for their efforts in helping to move the process along in getting the guidelines developed and approved.

Chair's Report

Dr. Martin informed the Board that the Federation of State Medical Boards (FSMB) will be holding a meeting in San Antonio, Texas on May 1-3, 2008 and the Board has been invited. He asked that Board members notify Staff if they are interested in attending. Dr. Martin informed Board members that the Board's yearly election of officers is scheduled for February 2008. He asked members to notify Ms. Diehl if they are interested in serving as the Chairman, Vice Chair, or Secretary.

Recognition of Christine Cassetta's Service as Board Counsel

The Board presented Ms. Cassetta with a plaque from the Board in recognition for her years of service as Board Counsel and her role in helping to protect the public. As a token of the Board's appreciation, Dr. Martin presented Ms. Cassetta with a gift from Board members. Ms. Cassetta stated that working with the Board had been a wonderful experience and she thanked the Board and Staff for their support throughout the years.

Consideration and Approval of April 2008 Board Meeting Date Change

Dr. Martin informed the Board that he would not be available for the April 2008 Regular Session Meeting and asked Board members to consider moving the meeting date to April 2 and 3, 2008. All Board members were in agreement with the revised date.

Update on Assistant Attorney General's Roles and Responsibilities

Presentation by Attorney General's Office: Terri Skladany, Chief Deputy; and Pamela Culwell, Division Chief Counsel.

Dr. Martin stated that he was instructed in February 2007 to work with the Attorney General's (AG's) Office to find a way to improve their process to continue making the Agency as strong as possible. Ms. Skladany addressed the Board and stated she once served in the capacity of providing independent legal advice for the Board. She stated that the AG's Office is committed to working with the Board and many individuals are working hard on the Board's behalf. Ms. Culwell also addressed the Board. She said she had been working with Dr. Martin and they have focused on three areas that need improvement. Those areas are: inconsistent legal advice, quality of service, and timeliness of service. She said they will be hiring a central advisor position, separate from the Solicitor General's Office, who will have a great deal of responsibility. This advisor will give legal services reports to the Board at Board meetings. The focus will be on accountability and visibility and what the advisor and litigators do outside of the Board when they are not preparing for formal hearings or Board meetings. The advisor will be responsible for coordinating, prioritizing, and reviewing services provided to the Board by the litigators. She stated that this is a way for the Board to best proportion responsibility and help ensure overall quality. She also said that this would make the litigators and/or advisor more responsible for the advice provided to the Board. The advisor will also draft memorandums to the Board in response to requests for rehearing or review that arise from formal interviews. She said the advisor position will also be responsible for responding to subpoenas. Anne Froedge, Assistant Attorney General, has currently assumed the advisor duties for the AG's office to obtain an assessment of the amount of time that it takes to perform the duties of the advisor. The position will be refined as they move forward, and Ms. Culwell asked the Board to provide feedback.

Ms. Culwell said that at the end of each calendar quarter, she would like to meet with one Board member, the Executive Director, and a few Staff members to review cases that had been closed within that calendar quarter. She stated they will have the ability to communicate expectations and be accountable for the decisions made. Ms. Culwell addressed the Board's backlog situation at the Office of Administrative Hearings. She said a number of the backlogged cases have been assigned to outside counsel. She believed the backlog occurred due to several hundred cases that were not investigated in 2005. She said these cases are starting to approach the end of the adjudication process. She said that the backlog is anticipated to be resolved within another six months to one year. She concluded her presentation by stating that the Board is entitled to high quality advice and the best representation that there is. Dr. Mackstaller stated she was concerned that, at times, the Board did not feel support by the AG's office. Dr. Krishna said the relationship between the Board and the AG's office needs to be mended as there has not always been open communication between both. Dr. Pardo questioned the change in the position that was previously held by Christine Cassetta, former Board legal counsel. Ms. Skladany informed the Board that in 1999, the Executive Director of the Board determined that the Board wanted to invest in having the advisor at the Board's offices; however, this was not how it always was. Ms. Skladany said they would like to return to the more traditional model to ensure that the day-to-day legal advice is consistent. The Board noted that the AG's office and the Board are working in the same direction to protect the public and to be fair to the physicians of Arizona. Dr. Martin thanked both Ms. Skladany and Ms. Culwell for addressing the Board and their participation in moving forward with this matter.

Approval of Minutes

MOTION: Dr. Krishna moved to approve the October 10-11, 2007 Regular Session Meeting Minutes, Including Executive Session; the October 11, 2007 Summary Action Meeting Minutes; and the October 15, 2007 Emergency Teleconference Meeting Minutes, Including Executive Session.
SECONDED: Dr. Petelin
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

REVIEW OF EXECUTIVE DIRECTOR DIMISSALS

MOTION: Ms. Griffen moved to uphold the ED dismissal in item numbers 1-11, excluding number 10.
SECONDED: Ms. Proulx
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0072A	S.S.	MAY H. MOHTY, M.D.	20459	Uphold ED Dismissal
2.	MD-07-0232A	N.B.	RUSSELL G. COHEN, M.D.	25011	Uphold ED Dismissal
3.	MD-07-0665A	L.W.	PHILIP M. SCHAP, M.D.	15371	Uphold ED Dismissal
4.	MD-06-0825A	B.H.	DANIEL M. GLICK, M.D.	15897	Uphold ED Dismissal
5.	MD-06-1024A	S.M.	ASHWINIKUMAR R. PATIL, M.D.	31751	Uphold ED Dismissal
6.	MD-07-0004A	I.G.	DAVID S. KABA, M.D.	33734	Uphold ED Dismissal
7.	MD-07-0042A	A.G.	ROBERT D. GRIEGO, M.D.	20349	Uphold ED Dismissal
8.	MD-07-0253A	L.M.	DUANE L. MITZEL, M.D.	14934	Uphold ED Dismissal

LM addressed the Board during the call to public. LM saw Dr. Mitzel for eye surgery to remove her congenital cataracts. She stated that after Dr. Mitzel assured her the surgery would improve her vision, he did not correct her astigmatism and her sight worsened. LM said she was informed by subsequent physicians that the wrong implants were used by Dr. Mitzel. She stated she required multiple corrective surgeries and still has to wear glasses for her poor vision.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-07-0265A	V.D.	STANLEY W. HOROWITZ, M.D.	12077	Uphold ED Dismissal
10.	MD-07-0443A	D.L.	MARLOU B. HEILAND, M.D.	33507	Uphold ED Dismissal

DL was present and spoke during the call to public on behalf of patient PG. DL stated Dr. Heiland missed the diagnosis of prostate cancer on five separate occasions. She urged the Board to reconsider the Dismissal as there should be consequences for Dr. Heiland's failures. Kelly Sems, M.D., Chief Medical Consultant, summarized the case for the Board. PG presented to Dr. Heiland on five separate occasions with an elevated PSA and was subsequently diagnosed with prostate cancer by another physician. She informed the Board that the Outside Medical Consultant (OMC) found no deviation from the standard of care. Dr. Sems said that in elderly patients it is not common for urologists to evaluate PSAs frequently.

MOTION: Dr. Krishna moved to uphold the ED Dismissal.
SECONDED: Dr. Petelin

Dr. Krishna said PG's age is a mitigating factor and even if the PSAs had been taken more frequently the treatment plan would have remained the same. Dr. Mackstaller stated that elderly patients still have the opportunity to live longer when treated appropriately. She was also concerned that PG was not offered other treatment options. Dr. Krishna noted that PG had multiple medical issues.

VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-07-0455A	F.H.	MARY M. DESCH, M.D.	25883	Uphold ED Dismissal

ADVISORY LETTERS

MOTION: Dr. Mackstaller moved to issue Advisory Letters for item numbers 1-19, excluding 5, 7, 8, 13, 16, and 17.
SECONDED: Ms. Proulx
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0600A	AMB	DAVID D. VAUGHN, M.D.	33512	Issue Advisory Letter for action taken by another Board.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					This matter does not rise to the level of discipline.
2.	MD-07-0244A	E.N.	TIMOTHY L. HODGES, M.D.	31263	Issue Advisory Letter for failing to obtain informed consent and inadequate medical records. This matter does not rise to the level of discipline.

Mike Ryan was present and spoke during the call to public on behalf of Dr. Hodges. He noted there were concerns that Dr. Hodges failed to obtain informed consent and failed to discuss with EN the different types of lenses available. Mr. Ryan said Dr. Hodges is adamant that he did discuss the different lenses with EN. He said this was a judgment call for Dr. Hodges and he exceeded the standard of care by having the discussion. He concluded that there was appropriate informed consent obtained and that this matter did not warrant an Advisory Letter.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0828A	S.Z.	THOMAS F. NORTON, M.D.	7469	Issue Advisory Letter for inadequate medical records. This matter does not rise to the level of discipline.

Drs. Goldfarb and Pardo were recused from this case.

4.	MD-07-0350A	K.V.	LINDSAY WORRELL, M.D.	29460	Issue Advisory Letter for providing anti-tussives/decongestants to a four month old patient.
5.	MD-07-0319A	C.G.	RANJIT K. SOOD, M.D.	10691	Issue Advisory Letter for failure to open and mature the colostomy in a timely manner. Obtain 20 hours non-disciplinary CME in colon surgery to be completed within three months. This was a minor or technical error that does not rise to the level of discipline.

Dr. Goldfarb pulled this case for discussion. William Wolf, M.D., Medical Consultant, summarized the case for the Board. It was alleged that Dr. Sood failed to diagnose, order appropriate studies, and provide adequate follow up care. Staff found Dr. Sood deviated from the standard of care by failing to open and mature the colostomy at the time of surgery. Staff believed this was a minor or technical error that does rise to the level of discipline. The Board noted that this was a minor technical error and the other allegations were not substantiated. Dr. Pardo was concerned with Dr. Sood's use of an outdated technique and wondered if he would benefit from obtaining non-disciplinary CME. Dr. Petelin noted Dr. Sood had an extensive Board history and opined that the non-disciplinary CME may be beneficial.

MOTION: Dr. Goldfarb moved to issue the Advisory Letter for failure to open and mature the colostomy in a timely manner. Obtain 20 hours non-disciplinary CME in colon surgery to be completed in three months. This was a minor technical error that does not rise to the level of discipline.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-07-0203A	AMB	GRANT HEINZ, M.D.	24590	Issue Advisory Letter for failing to remove corneal protectors after surgery and for failing to adequately supervise or direct his medical staff. This matter does not rise to the level of discipline.
7.	MD-07-0243A	J.T.	DOUGLAS A. SLAUGHTER, M.D.	23614	Issue Advisory Letter for failure to inform the Board that he terminated his relationship with a physician assistant that he previously supervised. This is a one time occurrence that does not rise to the level of discipline.

Dr. Martin stated he knew Dr. Slaughter but it would not affect his ability to adjudicate the case. Dr. Pardo pulled this case for discussion as she was concerned that Dr. Slaughter misinterpreted the statute requiring both the supervising physician (SP) and the physician assistant (PA) to notify the Board once the SP is not longer supervising the PA. Dr. Goldfarb noted that this requirement is clear on the paperwork filed by both the PA and SP during the Board's approval process. Staff informed the Board that the PA also failed to notify the Board of the termination and has recently been disciplined by the PA Board. Dr. Krishna said he felt Dr. Slaughter should have notified the Board whether it was a resignation or not. The Board concluded that the SP is responsible for the PA until the Board is notified that the relationship has been terminated.

MOTION: Dr. Krishna moved to issue the Advisory Letter for failure to inform the Board that he terminated his relationship with a physician assistant that he previously supervised. This is a one time occurrence that does not rise to the level of discipline.
SECONDED: Dr. Goldfarb
VOTE: 6-yay, 5-nay, 0-abstain, 0-recuse, 1-absent.

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-07-0260A	C.M.	ROBERT K. NIMLOS, M.D.	12857	Issue Advisory Letter for inadequate medical records and improper follow up. This matter does not rise to the level of discipline.

Mr. Paul Forrest addressed the Board during the call to public. He gave a brief overview of the case and reminded the Board that the Medical Consultant (MC) who reviewed this case found no deviation from the standard of care. Staff found Dr. Nimlos failed to maintain adequate medical records; however, Mr. Forrest stated this was based on the documentation of the nurses that were involved in CM's care. He said Dr. Nimlos had no control over what the nurses were noting in the chart; therefore, it would not be proper for the Board to hold him accountable for the poor records. Mr. Forrest asked that the Board reconsider the recommended Advisory Letter as Dr. Nimlos' care was not in question. Bhupendra Bhatheja, M.D., Medical Consultant, summarized the case for the Board. Staff found that Dr. Nimlos failed to maintain adequate medical records as there were only a limited number of vitals documented in the medical record during the several hours sustained in the emergency room. Dr. Petelin was concerned with the attempt by the emergency room physician to obtain EMT transportation for CM. He opined that other than his poor proof of monitoring in the medical record, Dr. Nimlos acted appropriately. The Board noted that there were six different notations in the chart that indicated Dr. Nimlos attempted to refer CM to a specialist. The Board concluded that Dr. Nimlos' documentation and monitoring was poor and stated the Advisory Letter was appropriate.

MOTION: Dr. Krishna moved to issue the Advisory Letter for inadequate medical records and improper follow up. This matter does not rise to the level of discipline.
SECONDED: Dr. Mackstaller

Dr. Mackstaller was concerned with the limited number of laboratory reports in the medical record and that there was no follow up documented. Dr. Krishna said he felt the Advisory Letter was appropriate. The Board requested that this matter be referred to the Arizona Department of Health Services.

VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-07-0451A	D. J.	MYTIA S. MCNEAL, M.D.	33478	Issue Advisory Letter for failing to examine a swollen testicle and for inadequate medical records. This matter does not rise to the level of discipline.

DJ addressed the Board during the call to public and said that Dr. McNeal failed to examine his son regarding his swelling on two separate occasions. He said Dr. McNeal should have consulted a specialist and ordered an ultrasound in a timelier fashion. DJ said that for a period of two months, his son was unable to participate in any physical activity. He asked that the Board consider issuing Dr. McNeal discipline rather than an Advisory Letter.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-07-0168A	AMB	NILO GOMEZ, M.D.	20075	Issue Advisory Letter for failure to properly read radiologic images. This matter does not rise to the level of discipline.
11.	MD-07-0300A	F.G.	JEFFREY SCHWIMMER, M.D.	7119	Issue Advisory Letter for failure to maintain adequate medical records. This matter does not rise to the level of discipline.
12.	MD-07-0048A	C.B.	CURTIS P. PAGE, M.D.	29288	Issue Advisory Letter for failure to properly dispense medications and failure to maintain adequate medical records. 10 hours non-disciplinary CME in medical recordkeeping. This was a minor or technical error.
13.	MD-07-0224A	AMB	SCOTT J. CRAWFORD, M.D.	10293	Return for further investigation to address the ureteral injury.

Dr. Petelin pulled this case for discussion as he was concerned that the injury to the patient's right ureter was not addressed in this case. Ingrid Haas, M.D., Medical Consultant, summarized the case for the Board. The patient underwent a hysterectomy that resulted in injury to the right ureter. Dr. Haas said she was instructed to address the issue regarding Dr. Crawford's failure to properly follow up with the patient. Kelly Sems, M.D., Chief Medical Consultant, informed the Board that when cases are reviewed by medical consultants, they are instructed to address the allegations of the complaint. She said the medical consultants can be instructed to opine outside of the initial allegations, if there are any concerns not addressed by the complaint.

MOTION: Dr. Krishna moved to return this case for further investigation to address the ureteral injury.
SECONDED: Dr. Mackstaller
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-07-0205A	AMB	JACK AJMERI, M.D.	31832	Issue Advisory Letter for failing to review the three way abdomen series obtained during the emergency room evaluation. This case does not rise to the level of discipline.
15.	MD-07-0267A	E.V.	STUART R. SNIDER, M.D.	13137	Issue Advisory Letter for failing to properly terminate the physician-patient relationship in writing and for failure to provide a reasonable time period to transition care to another neurologist. This matter does not rise to the level of discipline.
16.	MD-07-0364A	E.L.	TERRY L. SIMPSON, M.D.	21784	Return for further investigation.

Dr. Martin stated he knew Dr. Simpson but it would not affect his ability to adjudicate the case. Dr. Simpson addressed the Board during the call to public with his legal counsel, Mr. Stephen Myers. Dr. Simpson presented the Board with the instrument he used during the procedure that he conducted on EL. Dr. Simpson disagreed with the medical consultant's review and summary of this case and stated did not perform a colovaginal anastomosis as reported by Board Staff. Mr. Myers also addressed the Board and stated that the pathology was not indicative of a colovaginal anastomosis. He asked that the Board dismiss this case or invite Dr. Simpson in for a formal interview for a chance to discuss. Dr. Petelin pulled this case for discussion. William Wolf, M.D., Medical Consultant, summarized the case for the Board. Staff found Dr. Simpson deviated from the standard of care by performing a colovaginal anastomosis when he attempted to perform a colorectal anastomosis resulting in a colovaginal fistula. Dr. Wolf said it was not clear in the medical record that EL ever had stool per rectum during her post-operative stay at the hospital. It was four days post-operatively that EL reported stool per vagina. Dr. Petelin was concerned by Dr. Simpson's statements from the call to public as he did not seem to have any insight on the egregious technical error that he made. Dr. Petelin suggested Dr. Simpson obtain non-disciplinary CME hours in the risks and treatment in this type of complication. Dr. Petelin noted that Dr. Simpson was not present for part of EL's post-operative follow up that was covered by Dr. Arnold. He opined that Dr. Arnold deviated from the standard of care by allowing EL to be discharged. Dr. Petelin said Dr. Arnold should have referred EL for testing or he should have waited for Dr. Simpson to return before discharging EL. The Board recommended returning the case for further investigation and opening an investigation regarding Dr. Arnold's involvement in the post-operative care provided to EL during Dr. Simpson's absence.

MOTION: Dr. Petelin moved to return this case for further investigation.
SECONDED: Dr. Schneider
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-07-0389A	R.S.	NEIL M. HAY-ROE, M.D.	25189	Issue Advisory Letter for failing to properly treat trochanteric bursitis in the emergency room and for failing to choose a narcotic pain medication that would cause the least amount of side effects. This matter does not rise to the level of discipline.

Dr. Hay-Roe addressed the Board during the call to public. He stated he acted appropriately in the care of RS as he conducted an adequate history and physical and prescribed the appropriate pain medication that she responded well to. Dr. Lee questioned if the standard of care required an emergency room physician to immediately seek consultation in the treatment of chronic bursitis, or if it required an emergency room physician to ultimately seek care for the disease. He also questioned whether there were other medications that may have been used in place of the morphine. Carol Peairs, M.D., Medical Consultant, informed the Board that the morphine prescription was not the issue and that the issue was the amount of morphine Dr. Hay-Roe prescribed. Dr. Lee said he did not see any order for follow up in the medical records and Dr. Goldfarb noted that the emergency room was part of a major medical center and stated that there must have been a specialist available to see RS.

MOTION: Dr. Lee moved to issue the Advisory Letter for failing to properly treat trochanteric bursitis in the emergency room and for failing to choose a narcotic pain medication that would cause the least amount of side effects. This matter does not rise to the level of discipline.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
18.	MD-07-0539A	C.F.	WILLIAM L. SUN, M.D.	33617	Issue Advisory Letter for failing to obtain adequate informed consent for tubal ligation and for inappropriately changing a patients due date utilizing a third trimester ultrasound to determine the date. This matter does not rise to the level of discipline.
19.	MD-07-0563A	J.M.	KENNETH R. FRASER, M.D.	7913	Issue Advisory Letter for failing to use non-latex

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					examination gloves on a patient who is latex allergic.

OTHER BUSINESS

MOTION: Dr. Krishna moved to accept Other Business item numbers 1-3.
SECONDED: Dr. Lee
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Krishna moved to accept Other Business item numbers 4 and 5.
SECONDED: Dr. Lee
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Krishna moved to accept Other Business item numbers 6, 7, and 23.
SECONDED: Ms. Griffen
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0250A	AMB	FRANCIS J. WOO, M.D.	10705	Accept proposed consent agreement for a Letter of Reprimand for failing to recommend a colonoscopy for an 81 year old male patient.
2.	MD-07-0436A	AMB	KEITH N. LEVITT, M.D.	26382	Accept proposed consent agreement for surrender of an active license.
3.	MD-07-0245A	AMB	M. CECILIA D. DIMAANO, M.D.	13509	Accept proposed consent agreement for a Letter of Reprimand for failing to respond to hospital staff in a timely manner or at times, not at all and for failure to examine, evaluate and monitor patients on a regular basis.
4.	MD-04-0567A	AMB	ANCA N. MARAS, M.D.	13103	Rescind referral to Formal Hearing and accept proposed consent agreement for a Decree of Censure for failure to timely obtain appropriate laboratory tests, for failure to adequately monitor and treat a patient's blood loss and asses the patient's hemoglobin and hematocrit levels and for failure to maintain adequate medical records. Five year Probation to include random chart reviews. Physician shall practice in a group setting.
5.	MD-06-0655A	R.G.	ANGELO L. CHIRBAN, M.D.	27055	Rescind Referral to Formal Hearing and accept proposed consent agreement for a Letter of Reprimand for failure to appropriately supervise a physician assistant, for failure to file a Notice of Supervision application, and for failure to obtain Board approval for prescribing schedule II and III controlled substances by a physician assistant.
6.	MD-07-0076A	AMB	NILS E. FOLEY, M.D.	32906	Accept proposed consent agreement for a Letter of Reprimand for performing general anesthesia while under the influence of Demerol, for habitual intemperance and for violating a Board Order. Five year

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					Probation with MAP terms and a Two year Practice Restriction from practicing anesthesia.
7.	MD-07-0585A	AMB	JAMES A. MC GLAMERY, M.D.	10971	Accept proposed consent agreement for license reactivation. Five year Probation with MAP terms.
8.	MD-07-0378A	AMB	THEODORE T. HOFSTEDT, M.D.	23010	Dismiss.

Dr. Petelin pulled this case for discussion. Gerald Moczynski, M.D., Medical Consultant, summarized the case for the Board. Staff found that Dr. Hofstedt met the standard of care in this case and recommended the Board dismiss the complaint. Dr. Petelin was concerned with the type of medication administered to the patient. The Board noted the patient required a pain pump as he sustained injury to his artery and vain by another physician, Dr. Weng, following surgery. Dr. Moczynski opined Dr. Hofstedt was correct in discontinuing the patient's pain pump as there was a concern of numbness and tingling. Dr. Petelin opined that an Advisory Letter would be more appropriate in this matter.

MOTION: Dr. Petelin moved to reject the Dismissal and place the case on a future agenda with the recommendation of an Advisory Letter for failure to recognize the vascular deficiency that existed at the time that Dr. Hofstedt saw the patient.
SECONDED: Ms. Griffen

Dr. Krishna spoke against the motion and said that there was documentation to support that Dr. Hofstedt acted appropriately. Dr. Martin spoke against the motion and said the case should be dismissed.

VOTE: 2-yay, 9-nay, 0-abstain, 0-recuse, 1-absent.
MOTION FAILED.

MOTION: Dr. Krishna moved to dismiss this case.
SECONDED: Dr. Lee
VOTE: 10-yay, 1-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-07-0463A	AMB	JOHN D. HOLMES, M.D.	15472	Dismiss.

Dr. Martin was recused from this case.

MOTION: Dr. Mackstaller moved to dismiss this case.
SECONDED: Ms. Proulx
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-81-0086	AMB	JOSEPH L. MC CREADY, M.D.	6176	Grant the physician's request for termination of Board Order under the condition that Dr. McCready states in writing that if he intends to return to ophthalmology that he must notify the Board 30 days prior that he has the fund of knowledge to safely practice ophthalmology.

Kathleen Muller, Physician Health Program Manager, informed the Board that Dr. McCready requested the Board terminate his previous Board Order as he has not practiced ophthalmology since 2000 and has no intention of practicing ophthalmology in the future. Staff recommended that if Dr. McCready resumes practicing ophthalmology, he notify and demonstrate to the Board that he has the appropriate fund of knowledge to do so. The Board noted that if it were to terminate the Order, Dr. McCready would be able to return to practice as he pleased.

MOTION: Dr. Krishna moved to grant the physician's request for termination of Board Order under the condition that Dr. McCready states in writing that if he intends to return to ophthalmology that he must notify the Board 30 days prior that he has the fund of knowledge to safely practice ophthalmology.
SECONDED: Dr. Lefkowitz
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-07-L027A	AMB	PAUL W. LARSON, M.D.	N/A	This matter was pulled from the agenda.

Mr. Paul Forrest addressed the Board during the call to public on behalf of Dr. Larson regarding the denial of his postgraduate licensure. Dr. Larson was interviewed by Board Staff during the course of the investigation and it was recommended that he undergo drug and alcohol testing. Dr. Larson complied and underwent an assessment at the Betty Ford Center. Betty Ford

recommended Dr. Larson undergo residential treatment, which he did in Chicago, Illinois. Mr. Forrest stated that Dr. Larson was denied his postgraduate licensure prior to completing treatment. Following treatment, Dr. Larson's treating physicians have opined that he is safe to return to his postgraduate residency.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-07-L029A	AMB	DANIEL V. TUFARIELLO, M.D.	N/A	Deny Appeal of ED Denial of License.

The Board noted that Dr. Tufariello's most recent relapse was in 2005. The Board also noted that Dr. Tufariello answered appropriately on his license application, but did not disclose his prior history of substance abuse in 1993. The Board concluded that Dr. Tufariello met the criteria for the Board's "three strike" policy.

MOTION: Dr. Krishna moved to deny the appeal of the ED denial of licensure.
SECONDED: Ms. Griffen
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-06-0848A	AMB	ISRAEL V. FERNANDO, M.D.	27479	Deny Appeal of ED Referral to Formal Hearing.

Dr. Fernando had been practicing in Iowa while his Arizona license was on inactive status. Dr. Fernando was offered the opportunity to surrender his license and declined; therefore, the Executive Director (ED) referred him to the Office of Administrative Hearings for a full evidentiary Formal Hearing. Dr. Fernando's attorney requested that the Board reconsider the ED's referral to formal hearing as Dr. Fernando has no intention to return to practicing medicine in Arizona.

MOTION: Dr. Goldfarb moved to deny the appeal of ED referral to formal hearing.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-06-0062A	AMB	STEPHEN P. SUTTON, M.D.	28812	Continue the matter to allow more time to review the material.

MOTION: Dr. Martin moved to go into executive session.
SECONDED: Dr. Lee
Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 3:52 p.m.
The Board returned to Open Session at 4:02 p.m.
No deliberations or discussions were made during Executive Session.

Emma Mamaluy, Assistant Attorney General, briefly summarized the facts of the case for the Board. The Board found in May 2007 that Dr. Sutton committed unprofessional conduct under A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public; and A.R.S. §32-1401 (27)(ll) - Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient. Dr. Sutton's case involved two urology patients with issues regarding the antibiotics used in one case and whether or not a nephrectomy was appropriate in the other. Dr. Petelin stated he had not reviewed the material from Dr. Sutton. The Board recommended continuing this matter to allow more time to review the material submitted by Dr. Sutton.

MOTION: Dr. Lee moved to continue the matter to allow more time to review the material.
SECONDED: Dr. Griffen
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-06-0554A	AMB	CESAR VILLARREAL, M.D.	30915	Deny Motion for Rehearing or Review.

Mr. David Derickson addressed the Board during the call to public on behalf of Dr. Villarreal. Mr. Derickson stated there was no substantial evidence presented in the case to support discipline. He said there was misinformation presented to the Board when it considered the matter. Mr. Derickson asked that the Board reconsider this matter as Dr. Villarreal was found innocent and the case was dismissed in court with prejudice.

MOTION: Ms. Griffen moved to deny the motion for rehearing or review.
SECONDED: Dr. Pardo
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	RESOLUTION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-06-0927A	P.C.	NEIL TRACHTENBERG, M.D.	10078	Deny Motion for Rehearing or Review.

Dr. Trachtenberg addressed the Board during the call to public. He said he realized he performed a procedure on PC that she did not want and that if he had known that she did not want the procedure, he would not have done it. He said his mistake caused PC no harm and it was an appropriate and beneficial procedure that he highly recommended to her. Dr. Trachtenberg said he made every effort to contact her post-operatively to apologize and explain what happened. He said he waived his fees for the procedure and asked that the Surgicenter do the same. He said a non-disciplinary Advisory Letter would be more appropriate in this matter.

MOTION: Dr. Krishna moved to deny the motion for rehearing or review.
SECONDED: Ms. Griffen
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-06-0456A	BANNER ESTRELLA MEDICAL CENTER	MICHAEL R. ROLLINS, M.D.	30379	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to timely operate on a patient with post-operative complications.

MOTION: Dr. Krishna moved to accept draft Findings of Fact, Conclusions of Law and Order for Other Business item numbers 17-22, excluding number 18.
SECONDED: Dr. Petelin
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
18.	MD-06-0358A	L.N.	STEPHEN O. MORRIS, M.D.	10800	Accept draft Findings of Fact, Conclusions of Law and Order, as amended, for a Letter of Reprimand for failure to diagnose and monitor a patient considered to be high risk for drug abuse; for inappropriate prescribing; and for inadequate medical records.

Dr. Pardo pulled this case for discussion. She noted that the draft Findings of Fact, Conclusions of Law and Order indicated that LN committed suicide rather than overdosed. Dr. Pardo said the record does not indicate that LN committed suicide, only that at times he had suicidal tendencies. Dr. Lee noted that LN's death was not a definitive suicide.

MOTION: Dr. Pardo moved to accept the draft Findings of Fact, Conclusions of Law and Order, as amended, for a Letter of Reprimand for failure to diagnose and monitor a patient considered to be high risk for drug abuse; for inappropriate prescribing; and for inadequate medical records.
SECONDED: Dr. Lee
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-06-0667A	C.W.	PATRICIA L. CLARKE, M.D.	26877	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to appropriately evaluate a patient with multiple medical issues and for failing to maintain adequate medical records. One year Probation to include 20 hours CME in diagnosis and treatment of fluid and electrolyte abnormalities. Probation to terminate upon completion of the CME.
20.	MD-06-0067A	T.A.	CHARANJIT S. DHILLON, M.D.	11273	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inappropriate billing and failure to provide a patient's medical record to a subsequent treating physician. One year Probation to include 20 hours CME in billing and coding and documentation to support the billing and coding. Probation to terminate upon completion of CME.

TA was present and spoke during the call to public. She thanked the Board for their consideration of her complaint.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-06-1042A	N.G.	ALAN C. SACKS, M.D.	9475	Accept draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing or refusing to maintain adequate medical records on a patient.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
22.	MD-06-0936B	AMB	PARVEZ P. JESSANI, M.D.	22709	Accept draft Findings of Fact, Conclusions of Law and Order, as amended, for a Letter of Reprimand for failure to seek the cause of the patient's nausea and vomiting; failure to aggressively treat symptomatically the patient's persistent hypotension and acidosis; failure to recognize the acidosis; failure to use standard tests and monitoring modalities to assess the effectiveness of the treatment course; and failure to seek information or appropriate consultation to clarify whether the disease could affect the patient's present and presenting condition.

Dr. Lee pulled this case for discussion. He noted that Dr. Jessani's attorney requested several significant and substantial changes to the Board's original draft. Dr. Lee said that if the Board were to accept the attorney's changes entirely, it would remove the Board's concerns and intention. The Board agreed to each of the attorney's grammatical changes to the draft. Under Findings of Fact, the Board agreed to reword that Dr. Jessani saw the patient *that morning* as the notes in the chart were not timed, but only dated. The Board did not accept the attorney's revision removing that Dr. Jessani did not recognize the acidosis from the Findings of Fact and Order.

MOTION: Dr. Lee moved to accept the draft Findings of Fact, Conclusions of Law and Order as amended.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
23.	MD-07-0204A	AMB	MOHAMMED M. ALAM, M.D.	29511	Accept proposed consent agreement for a Letter of Reprimand for failure to properly manage an unstable hospitalized patient with persistent tachycardia and decreasing hemoglobin

Thursday, December 13, 2007

Call to Order
The meeting was called to order at 9:30 a.m.

Roll Call
The following Board Members were present: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was not present: Mr. Eckstrom

Call to Public
JK was present and spoke during the call to public regarding a case that was previously dismissed by the Board. He asked the Board to reconsider the matter to solve his son's death. All other statements issued during the call to public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0124A	J.M.	JAMES H. KAPNER, M.D.	14167	Issue Advisory Letter for inadequate medical records and for failure to document informed consent. Obtain 17 hours non-disciplinary CME in recordkeeping. The CME hours may be included with the hours for license renewal. This is a minor or technical violation.

Dr. Kapner was present with legal counsel, Mr. Jay Fradkin. William Wolf, M.D., Medical Consultant, summarized the case for the Board. Staff found Dr. Kapner deviated from the standard of care by failing to provide treatment options including radiation therapy, by performing the transurethral resection of the prostate (TURP) procedure too soon following patient NM's cryotherapy procedure, and by failing to aggressively address and treat NM's recurrent urinary tract infections (UTIs). Dr. Kapner also failed to document his discussion regarding treatment options. Staff found it mitigating that NM's infections were treated appropriately once diagnosed. Dr. Kapner said his documentation in the record clearly stated his analysis of NM's prostate cancer and the discussions regarding treatment options. He said he treated NM's infections appropriately and he documented each conversation he had with NM. Dr. Kapner said he did not understand the difficulty others have in reviewing his handwriting. Dr. Kapner said prostatectomy was not an option for NM as he was a high risk patient in his mid-eighties. Dr.

Kapner stated NM responded to the cryoablation and; therefore, did not believe secondary treatment was necessary. Dr. Kapner informed the Board he has taken steps to remediate the issue regarding the legibility of his notes. He said the standard in his practice now is to dictate each patient's encounter. Mr. Fradkin opined that Dr. Kapner's care was entirely reasonable and in the best interest of the patient. He said the timing of the TURP procedure was well within the appropriate standard of care. He noted that Dr. Kapner now dictates his notes so that his medical records will no longer be misinterpreted. The Board noted that the medical consultant who reviewed the case was critical only of the timing of the TURP procedure and Dr. Kapner's recordkeeping. The Board also noted that the medical consultant did not specify when the TURP should have been performed and that the patient harm was difficult to determine. The Board concluded that this matter does not rise to the level of discipline.

MOTION: Dr. Petelin moved to issue an Advisory Letter for inadequate medical records and for failure to document informed consent. Obtain 17 hours non-disciplinary CME in recordkeeping. The CME hours may be included with the hours for license renewal. This is a minor or technical violation.
SECONDED: Dr. Mackstaller

Dr. Petelin clarified that the non-disciplinary CME hours may be included with the hours required for Dr. Kapner's biennial license renewal.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-07-0318A	AMB	GREGORY J. CELAYA, M.D.	21703	Dismiss.

Dr. Petelin was recused from this case. Dr. Celaya was present with legal counsel, Mr. Joseph Kendhammer. Tina Geiser, Case Review Assistant Manager, summarized the case for the Board. At the Board's April 2007 meeting, the Board requested this case be opened as a result of Dr. Celaya's failure to report to the Board that Dr. Cecena's privileges at St. Luke's Hospital (St. Luke's) had been suspended, as required by the Arizona Medical Practice Act. Mr. Kendhammer informed the Board that St. Luke's assured Dr. Celaya that it would report the action to the Board, but never did. Dr. Celaya served as the Chief of Staff on the Executive Committee at St. Luke's at the time the action was taken against Dr. Cecena's privileges. Dr. Celaya said his duties included termination of physicians who placed any patients in danger. He was to make sure that the staff was aware when there was a situation in the hospital that required a closer look at a physician. Dr. Celaya was also to ensure that the St. Lukes' rules, regulations, and bylaws were followed during that time. The Board was informed that a letter reporting the action was drafted to the Board but was never submitted. Dr. Celaya assumed the action was reported by support staff to the Board. Dr. Celaya said he would make sure this does not happen again and stated that he is now aware of the statute; however, he no longer serves on the Executive Committee at St. Luke's. Mr. Kendhammer expressed that St. Luke's assumed full responsibility for the action that was not reported. He said St. Luke's realizes that the support staff should be more familiar with what is required by the Board. The Board is currently drafting a Substantive Policy Statement to address this issue, as similar cases have been before the Board previously. Dr. Goldfarb opined that Dr. Celaya should not be held responsible for St. Luke's failure to report the action. He said that in his experience from serving on an Executive Committee at a hospital, he relied mostly on the attorneys and support staff for guidance.

MOTION: Dr. Goldfarb moved to dismiss this case.
SECONDED: Dr. Lefkowitz

Dr. Krishna opined that issuing Dr. Celaya an Advisory Letter would be more appropriate so that this issue may be tracked by the Board. Dr. Pardo opined that as a professional, physicians have the responsibility to read and know the rules and regulations of the Board. Dr. Mackstaller said Dr. Celaya should not be held accountable for the hospital's failure.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom. The following Board Member was recused: Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

The Board instructed Staff to refer this matter to the Department of Health Services for the hospital's failure to report Dr. Cecena's suspension to the Board and the NPDB.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-07-0182A	J.R.	JAMES M. JOHNSON, M.D.	27769	Issue Advisory Letter for failing to adequately communicate with hospital staff regarding a high risk pregnant patient.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					There is insufficient evidence to support discipline.

Dr. John Elliot addressed the Board during the call to public in support of Dr. Johnson and opined that Dr. Johnson met the standard of care in this case. JR also addressed the Board during the call to public. She said there was no way of knowing whether or not her child may have survived, but she stated that Dr. Johnson failed in his responsibilities as her physician to prevent her child's death. She was discharged by the triage nurse who informed her that Dr. Johnson was aware of her status. Dr. Johnson was present with legal counsel, Mr. Richard Kent. Dr. Haas summarized the case for the Board. Staff found Dr. Johnson deviated from the standard of care by failing to adequately monitor and treat a high risk pregnancy and by failing to perform and/or order necessary testing. Dr. Johnson was not notified that JR was having a significant number of contractions per hour, nor was he informed of any bleeding. Triage nurses are qualified to determine if a pregnant patient was bleeding, contracting, and if they are okay to discharge. However, Dr. Johnson informed the Board that he was later made aware that the nurse who evaluated JR was not certified to practice in the triage. Mr. Kent claimed that Dr. Johnson did not authorize JR's discharge. Prior to JR presenting to the hospital, she called and spoke with a medical assistant (MA) who was trained to know what questions to ask. If any of the answers are negative, the patients are given precautions for them and advised to go to the hospital if problems occur. Dr. Johnson said his staff virtually directs patients to the triage if they have continuing complaints.

Dr. Johnson was contacted by the triage nurse after assessing JR's complaints. She informed him that JR presented with some pink discharge, but at the time, there was no bleeding or leaking and her evaluation was normal. Dr. Johnson informed the Board that the triage nurses have access to patient records, but he did not believe the triage nurse reviewed JR's records prior to discharging her. If the triage nurse would have reviewed JR's records, she would have realized JR had a bicornuate uterus. Dr. Johnson said he had access to JR's records from his home computer, but he did not feel it was necessary to review them as there were no significant findings when he was contacted by the triage nurse. Dr. Johnson opined that JR should have informed the triage nurse of her bicornuate uterus; however, he did not instruct JR to inform the nurses. Dr. Johnson stated if an ultrasound would have been performed at that time, JR would have been admitted for observation. He said the triage nurse did not allow him the opportunity to do so by informing him that JR's evaluation was normal. In closing, Dr. Johnson stated he has taken remedial action and now rechecks and questions the staff more thoroughly. He said he had discussions with JR and noted that he failed to document the discussions. Dr. Johnson said the outcome would not have been different had he assessed JR himself. Dr. Schneider noted this was a difficult case, but ultimately, Dr. Johnson assumed important facts from the nurse without asking the right questions, however; this may not have changed the outcome. Dr. Krishna said he could not find that Dr. Johnson had committed any unprofessional conduct with the management of JR. Dr. Pardo said it was the nurse's responsibility to pursue any issues with JR and to request help from Dr. Johnson. Dr. Pardo was concerned with the lack of communication by the triage nurse. Dr. Goldfarb opined that Dr. Johnson did not ask the appropriate questions when contacted by the nurse. The Board concluded that this matter does not rise to the level of discipline.

MOTION: Dr. Schneider moved for an Advisory Letter for failing to adequately communicate with hospital staff regarding a high risk pregnant patient. There is insufficient evidence to support discipline.
SECONDED: Dr. Goldfarb
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board instructed Staff to refer this matter to the Arizona Board of Nursing.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-07-0313A	L.S.	JOSEPH T. EDWARDS, M.D.	19400	Issue Advisory Letter for inadequate medical records. Obtain 17 hours non-disciplinary CME in recordkeeping. The CME will apply toward his biennial license renewal. There is insufficient evidence to support discipline.

Dr. Lefkowitz was recused from this case. Dr. Edwards was present without legal counsel. Dr. Haas summarized the case for the Board. Staff found that Dr. Edwards deviated from the standard of care by failing to perform a cystoscopy at the time he performed a vaginal vault distension on LS and by failing to evaluate her post-operative pubic pain. Dr. Edwards stated that LS's pain was due to previous surgeries in 2001, in which a sling was placed using anchors into the pubic bone. It was discovered by a subsequent physician that LS had a retained suture. Dr. Edwards said the suture was found too far from the area he operated on and; therefore, it was retained from a previous surgery. Dr. Edwards assured the Board that his practice now consists of patients of a younger age and he will not be exposed to this type of complication again. The Board noted that Dr. Edwards failed to document treatment options in LS's medical record. Dr. Edwards said that when he obtains patient consents, he informs the patient of the risks of the procedures. The Board also noted that Dr. Edwards' operative report was dictated twenty days after surgery. Dr. Edwards said dictating the report sooner would not have changed the outcome of the case. Dr. Edwards said he has remediated the medical records issue by only using electronic medical records in his current

practice. Several weeks post-operatively, LS began to complain of pain. Dr. Edwards said her complaints were not consistent with that of a sacro-spinous suspension complication. Dr. Mackstaller noted that LS's pain subsided following removal of the retained suture. Dr. Lee confirmed that the retained suture was not the same used by Dr. Edwards. Dr. Schneider noted that the subsequent urologist said that the suture was placed through the left bladder neck. Dr. Edwards testified to the Board that he only operates on the right because he is right handed. Dr. Lee opined that Dr. Edwards may have passed the suture during the procedure he performed, which may have caused pressure that created LS's symptoms following surgery. The Board concluded that Dr. Edwards did not commit unprofessional conduct and that this matter does not rise to the level of discipline.

MOTION: Dr. Schneider moved to issue an Advisory Letter for inadequate medical records. Obtain 17 hours non-disciplinary CME in recordkeeping. The CME will apply toward his biennial license renewal. There is insufficient evidence to support discipline.
SECONDED: Dr. Petelin
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom. The following Board Member was recused: Dr. Lefkowitz.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

FORMAL HEARING MATTERS – CONSIDERATION OF ADMINISTRATIVE LAW JUDGE (ALJ) RECOMMENDATION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0693A	AMB	VENU G. MENON, M.D.	12360	Revocation.

The Board confirmed that it received and reviewed the administrative record from the Formal Hearing. Emma Mamaluy, Assistant Attorney General, informed the Board that this matter involved Dr. Menon's violation of a Board Order. The State requested the Board modify Conclusions of Law numbers 5 and 6. Conclusions of Law number 5 indicated there was inconclusive evidence to support that Dr. Menon's care was substandard or that he endangered patients while practicing in Nebraska. Conclusions of Law number 6 addressed whether or not his absence from the country interfered with his ability to respond to the Board's Order for a Physician Assessment and Clinical Evaluation (PACE). Ms. Mamaluy noted that Dr. Menon's absence was after the due date to complete PACE. The State requested the Board revoke Dr. Menon's license to practice medicine in the State of Arizona.

MOTION: Dr. Lee moved to accept the ALJ's recommended Findings of Fact.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Krishna moved to accept the ALJ's recommended Conclusions of Law, with the exception of amending Conclusions of Law number 5 to state "the record *does* contain conclusive evidence that Dr. Menon's care of his patients at McCook Community Hospital in Nebraska was substandard or endangered those patients. *And* given Dr. Menon's admissions in the Nebraska settlement, the Board properly required an in-depth PACE evaluation" and to delete Conclusions of Law number 6.
SECONDED: Dr. Petelin
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Goldfarb moved to modify the ALJ's recommended Order to delete paragraphs 2 and 3, and Revoke Dr. Menon's license.
SECONDED: Dr. Petelin

The ALJ recommended stayed revocation allowing Dr. Menon the opportunity to undergo PACE. The Board noted that Dr. Menon had the opportunity to complete a PACE evaluation prior to leaving the country but failed to comply. The Board found Dr. Menon's conduct in Nebraska egregious and concluded to revoke Dr. Menon's license.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-1354A	AMB	RONALD A. BERNSTEIN, M.D.	15078	Issue Advisory Letter for violating a Board

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					Order. There has been substantial evidence of remediation.

Dr. Goldfarb was recused from this case. Ms. Mamaluy presented this case to the Board. The State and Dr. Bernstein requested the matter be held in executive session due to the sensitive nature of the case.

MOTION: Dr. Krishna moved to go into executive session.
SECONDED: Dr. Lee
Vote: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 4:01 p.m.
The Board returned to Open Session at 4:11 p.m.
No deliberations or discussions were made during Executive Session.

The Board confirmed that it received and reviewed the administrative record from the Formal Hearing. Ms. Mamaluy informed the Board that the ALJ sealed most of the case material, but did not seal the Recommended Order. The ALJ found that Dr. Bernstein provided an affirmative defense of impossibility of performance of the Order. Based on this the ALJ recommended dismissal of the case. Ms. Mamaluy stated that impossibility of performance is a contract issue and the State did not believe it applied in this matter. Therefore, the State asked that the Board reject Conclusions of Law numbers 4-9. Dr. Bernstein said he was initially seeing a Board-approved psychiatrist as required by the Order, but the physician terminated him as his patient. Dr. Bernstein sought treatment from multiple psychiatrists but was turned away. Seven months later Dr. Bernstein began seeing a Board- approved psychiatrist. Dr. Bernstein asked that the Board abide by the ALJ's recommendation for dismissal. Ms. Mamaluy informed the Board that Dr. Bernstein had been compliant with the Board's Order for the past two and a half years.

MOTION: Dr. Krishna moved to adopt the ALJ's recommended Findings of Fact.
SECONDED: Dr. Lee

Dr. Lee asked that the date be changed to December 13, 2004 in Finding of Fact number 11.

VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Krishna moved to adopt the ALJ's recommended Conclusions of Law 1-3 and reject Conclusions of Law 4-9.
SECONDED: Dr. Lee
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Krishna moved to reject the ALJ's recommended Order for Dismissal.
SECONDED: Dr. Lee

Dr. Mackstaller questioned whether the Board could uphold the recommendation for dismissal, but require that Dr. Bernstein continue treatment with a psychiatrist. Dr. Martin stated that once the case is dismissed, the Board no longer has jurisdiction over the matter as it will be closed. Ms. Mamaluy informed the Board that Dr. Bernstein was currently under an ongoing Board Order for psychiatric treatment. This matter was regarding his violation of that Order. She reminded the Board that Dr. Bernstein is still subject to the prior Order. The Board noted that in the past, it issued disciplinary action to physicians who have violated Board Orders.

VOTE: 6-yay, 4-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Martin moved to issue an Advisory Letter for violating a Board Order. There has been substantial evidence of remediation.
SECONDED: Dr. Lefkowitz

Dr. Lee spoke in favor of the motion and said there were incredible mitigating circumstances, but the Board should track Dr. Bernstein's Board history.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr.

Schneider. The following Board Member was absent: Mr. Eckstrom. The following Board Member was recused: Dr. Goldfarb.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0211A	AMB	DAVID D. PARRISH, M.D.	26896	Revocation.

Philip Overcash and Michael Sillyman, outside counsel for the Board, presented the case to the Board. The Board confirmed that it received and reviewed the administrative record from the Formal Hearing. The Board had issued Dr. Parrish an Interim Order for PACE and Dr. Parrish failed to comply. The Board issued Dr. Parrish a Letter of Reprimand and Probation for one year to undergo a PACE evaluation and Dr. Parrish indicated he would not comply with the Board's Order. Prior to the Formal Hearing, Dr. Parrish surrendered his medical license. The State requested the Board adopt the ALJ's recommended Findings of Fact with two grammatical corrections to numbers 13 and 14.

MOTION: Dr. Krishna moved to adopt the ALJ's recommended Findings of Fact 1-15, with grammatical changes in 13 and 14.
SECONDED: Ms. Proulx
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Krishna moved to adopt the ALJ's recommended Conclusions of Law.
SECONDED: Dr. Mackstaller
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Krishna moved to adopt the ALJ's recommended Order for Revocation.
SECONDED: Ms. Proulx
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-07-L020A	AMB	MEHDY ZARANDY, M.D.	N/A	Grant the license.

The Board confirmed that it received and reviewed the administrative record from the Formal Hearing. Dean Brekke, Assistant Attorney General, informed the Board that this matter involved denial of Dr. Zarandy's request for licensure. Dr. Zarandy's license application indicated that he attended a residency program, but did not disclose that he had been placed on probation during that period of time. Staff discovered he had been placed on probation for deficits in his knowledge base and interpersonal skills. The ALJ recommended granting Dr. Zarandy's license, and place him on Probation for one year.

MOTION: Dr. Krishna moved to adopt the ALJ's recommended Findings of Fact and Conclusions of Law.
SECONDED: Dr. Lee
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The State recommended the Board reject the probationary terms as the Board only had the authority to grant or deny a license. Probationary terms may only be imposed when they pertain to health issues. Dr. Pardo suggested the Board grant the license but in the Order establish that Dr. Zarandy's failure to disclose was careless.

MOTION: Dr. Krishna moved to modify the ALJ's recommended Order and Grant the license.
SECONDED: Dr. Petelin
VOTE: 10-yay, 0-nay, 1-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Friday, December 14, 2007

Call to Order
The meeting was called to order at 8:00 a.m.

Roll Call

The following Board Members were present: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was not present: Mr. Eckstrom

Call to Public

Keith King, M.D., was present and addressed the Board regarding a voluntary practice restriction he has had on his license for approximately twelve years. He said he was interested in having the Board modify the restriction.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
1.	MD-06-0959A	AMB	SYED TAHIR, M.D.	19801	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to maintain adequate records on a patient, for failing to review an x-ray he ordered to determine there were no foreign bodies left in the abdomen, and for failure to read subsequent radiologic reports.

Dr. Krishna was recused from this case. Dr. Petelin said he knew both Dr. Tahir and Mr. Stephen Yost, but it would not affect his ability to adjudicate the case. Dr. Tahir was present with legal counsel, Mr. Stephen Yost. William Wolf, M.D., Medical Consultant, summarized the case for the Board. Staff found Dr. Tahir deviated from the standard of care by failing to recognize the presence of retained sponges on intra-operative and post-operative films following an open cholecystectomy and common duct exploration. Staff found it mitigating that the nurses reported a correct sponge count to Dr. Tahir during the operation. Dr. Tahir said that initially the needle count was incorrect and the patient was sent for an x-ray. The x-ray results were negative, but Dr. Tahir did not review the lab report personally. Therefore, he missed the section of the lab report that referred to an unknown etiology retained in the patient's abdomen. Dr. Tahir requested the Board issue a non-disciplinary action as he has taken remedial action by requiring an x-ray prior to discharge on every patient that he performs open surgery on.

Dr. Tahir first attempted to perform a laparoscopy on the patient, but when he was unable to visualize the anatomy, he went on to do a laparotomy. Dr. Tahir said he did not document an incorrect needle count in the medical record because he knew he did not lose the needle inside the patient. He said he saw the needle fall to the floor and assumed it would be found eventually. The patient was sent for an x-ray following surgery due to the incorrect needle count. The x-ray was reported to be inadequate as the left side of the patient's abdomen was excluded from the film. Dr. Petelin opined that Dr. Tahir should have reviewed the report personally. Dr. Tahir said he personally reviews the reports when there is no radiologist available. Dr. Tahir phoned in to have the report read to him, but he hung up the phone before hearing that an unknown etiology was retained in the patient. Dr. Tahir preformed a second surgery on the patient to remove the two retained sponges sixteen days following the initial surgery. Dr. Tahir ordered an x-ray of the patient's abdomen post-operatively to assure the sponges were removed. However, there is no report for this x-ray in the patient's medical record. Dr. Goldfarb opined that it is the surgeon's responsibility to review his or her own labs as they would be more familiar with what part of the patient was operated on. Dr. Tahir agreed that had he reviewed the film personally, he would not have missed the retained sponges and the patient would not have required additional surgery. The Board found that Dr. Tahir failed to document the incorrect needle count, failed to personally review the x-ray to determine there were no foreign objects retained in the abdomen, failed to know the results of the x-ray prior to leaving the patient, and failed to make himself aware of the findings in the lab reports. The Board identified potential harm as the sponges were retained in the patient's abdomen when discharged.

MOTION: Dr. Petelin moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient; A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public; and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Dr. Goldfarb
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Petelin moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to maintain adequate records on a patient, for failing to review an x-ray he ordered to determine there were no foreign bodies left in the abdomen, and for failure to read subsequent radiologic reports.
SECONDED: Dr. Schneider

The Board was disturbed that Dr. Tahir allowed the patient to be discharged with a low white cell count and that this negated the mitigating factors. The Board also opined that had Dr. Tahir acted on the low white cell count prior to discharge, he would have had the opportunity to react to the retained sponges in a timelier fashion.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr.

Schneider. The following Board Member was recused: Dr. Krishna. The following Board Member was absent: Mr. Eckstrom.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent.
MOTION PASSED.

The Board instructed Staff to refer this matter to the Arizona Board of Nursing.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
2.	MD-07-0169A	AMB	MONICA M. BANERJEE, M.D.	32404	Issue an Advisory Letter for failing to be available for patients and hospital staff on multiple occasions and failing to maintain adequate medical records. This matter does not rise to the level of discipline.

Dr. Banerjee was present with legal counsel, Mr. Ed Hendricks, Jr. Dr. Petelin said he knew Mr. Hendricks but it would not affect his ability to adjudicate the case. Kathleen Coffer, M.D., Medical Consultant, summarized the case for the Board. In the multiple patient cases reviewed, Staff found Dr. Banerjee did not deviate from the standard of care in the clinical treatment of each patient with the exception that she failed to be available in a timely fashion for patients and hospital staff on multiple occasions. Staff also found Dr. Banerjee failed to maintain adequate medical records. Dr. Banerjee informed the Board that she was treating other patients when she was not immediately available on multiple occasions. She said she has taken steps to remediate her actions by attending medical records courses and time management courses. Additionally, she has undergone two psychotherapy examinations. Dr. Banerjee said that she understood that it is important to have adequate records immediately available to ensure the continuity of care. She said she is currently only working with two hospices and has a phone for each, and is available by e-mail and pager. Dr. Banerjee said she was overworked and overwhelmed during that period of time, but has taken remedial action to reduce the stressors from her life. The Board was concerned that should these stressors reoccur, Dr. Banerjee may repeat the actions that led her to this investigation. The Board questioned whether it should restrict Dr. Banerjee's practice to a limited number of hours. Dr. Banerjee said she would not allow herself to return to that type of lifestyle and would be willing to undergo any treatment the Board may recommend. Mr. Hendricks told the Board that this was only a ninety-day window in which Dr. Banerjee had over-extended herself. He said Dr. Banerjee has taken remedial action to assure the Board that it will not happen again and requested the Board issue her a non-disciplinary action. The Board concluded that Dr. Banerjee did commit unprofessional conduct in that she failed to maintain adequate medical records and failed to be available to patients and staff.

MOTION: Dr. Lee moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient; and A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Dr. Krishna
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Lee moved to go into executive session.
SECONDED: Dr. Krishna
Vote: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board went into Executive Session for legal advice at 10:24 a.m.
The Board returned to Open Session at 11:00 a.m.
No deliberations or discussions were made during Executive Session.

MOTION: Dr. Lee moved to issue an Advisory Letter for failing to be available for patients and hospital staff on multiple occasions and failing to maintain adequate medical records. This matter does not rise to the level of discipline.
SECONDED: Dr. Lefkowitz
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Lee moved to refer the physician to the Physician's Health Program to evaluate her for any continuing health care needs.
SECONDED: Dr. Goldfarb
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC.#	RESOLUTION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
3.	MD-07-0241A	AMB	JOHN R. KLEIN, M.D.	32166	Issue an Advisory Letter for failing to diagnose and recommend treatment for a fracture of the neck of the talus. This was a technical violation that does not rise to the level of discipline.

Dr. Klein was present with legal counsel, Mr. Paul Giancola. Dr. Martin said he knew Mr. Giancola, but it would not affect his ability to adjudicate the case. Gerald Moczynski, M.D., Medical Consultant, summarized the case for the Board. Staff found Dr. Klein deviated from the standard of care by failing to diagnose patient TH's fracture of the neck of the talus despite documentation of reviewing TH's x-rays on at least five separate occasions. Staff also found a deviation from the standard of care for failing to inform TH of the benefits, risks and complications of the choice fracture management because he failed to diagnose the talus fracture. Staff found it aggravating that Dr. Klein failed to diagnose the fracture and advise the patient of treatment options. Dr. Klein said he was contacted and presented to the emergency room to evaluate the patient. He said TH's lab report only noted a distal fibula, not a talar neck fracture. Dr. Klein allowed the patient to bear weight on the fracture because she declined surgery and he discharged her home as he thought the fracture was healed. The Board opined that Dr. Klein deviated from the standard of care by allowing the patient to walk on her ankle fracture when she had pain, swelling and stiffness. Dr. Klein took full responsibility for missing the diagnosis and agreed that the appropriate treatment would be further work up of the patient's ankle. Dr. Klein said that in his current practice, he tries to be more diligent in looking for other fractures that may be present. He said any of the bones in the foot and ankle may have been fractured in relation to the type of injury sustained by the patient. Mr. Giancola said Dr. Klein continued to look at the fibula and not the talus based on the diagnosis. The only harm was the delay in performing surgical intervention. He said this was a one time mistake and was not egregious. He said the mistake was repetitive but should not warrant a disciplinary action.

The Board opined the standard of care would have required the physician to accurately interpret x-rays and make recommendations for fracture management. The Board believed the outcome would not have changed had Dr. Klein acted differently. The Board concluded that this was a one time occurrence that does not rise to the level of discipline.

MOTION: Dr. Martin moved to issue an Advisory Letter for failing to diagnose and recommend treatment for a fracture of the neck of the talus. This was a technical violation that does not rise to the level of discipline.
SECONDED: Dr. Petelin
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, and Dr. Schneider. The following Board Member abstained: Ms. Proulx. The following Board Member was absent: Mr. Eckstrom.
VOTE: 10-yay, 0-nay, 1-abstain, 0-recuse, 1-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
4.	MD-05-1072A	C.B.	RICHARD H. WEYER, M.D.	11286	Issue an Advisory Letter for inadequate medical records. This was a minor technical violation that does not rise to the level of discipline.

Dr. Weyer was present with legal counsel, Ms. Anne Fulton-Cavett. Dr. Lee said he knew the medical consultant who reviewed this case but it would not affect his ability to adjudicate the case. Dr. Goldfarb said he knew both Dr. Weyer and Mr. Giancola but it would not affect his ability to adjudicate the case. Bhupendra Bhatheja, M.D., Medical Consultant, summarized the case for the Board. Staff found Dr. Weyer deviated from the standard of care by failing to treat and manage patient CB's squamous cell carcinoma (SCC) and by failing to consider performing a biopsy on the lesions that were unresponsive to liquid nitrogen treatments, and by failing to communicate directly with the patient's referring PA. Staff also stated Dr. Weyer's documentation was illegible. Dr. Weyer informed the Board that when he first saw CB, he had just returned from a leave of absence from undergoing cervical neck surgery. He said the physician assistant (PA) who referred CB to him did not communicate directly with Dr. Weyer. Dr. Weyer treated CB with multiple antibiotics for his multiple medical conditions. Dr. Weyer informed the Board that he has taken remedial action to prevent this from happening again. The Board noted the PA documented that Dr. Weyer was addressing CB's SCC. However, Dr. Weyer documented that the PA was handling CB's SCC. Dr. Weyer said that in retrospect, he would have been more proactive in treating the SCC. Dr. Weyer said the PA's supervising physician (SP) was also his primary care physician; therefore, he assumed the PA knew he had not returned to practice full time following his own surgery. Ms. Fulton-Cavett reminded the Board that Dr. Weyer has taken remedial action in his own practice and he now requires documented correspondence from physician to physician, including himself. She said it was significant to note that the complaint was originally dismissed and noted that the medical consultant who reviewed this case did not identify any patient harm. The Board did not find Dr. Weyer committed unprofessional conduct, with the exception of his recordkeeping.

MOTION: Dr. Mackstaller moved to issue an Advisory Letter for inadequate medical records. This was a minor technical violation that does not rise to the level of discipline.
SECONDED: Dr. Lefkowitz

The Board noted that Dr. Weyer has changed his practice to remediate the violation and believed CME would not be beneficial.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Goldfarb, Ms. Griffen, Dr. Krishna, Dr. Lee, Dr. Lefkowitz, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Dr. Petelin, Ms. Proulx, and Dr. Schneider. The following Board Member was absent: Mr. Eckstrom.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Staff informed the Board that the PA was referred to the Arizona Regulatory Board of Physician Assistants. Staff also informed the Board that the SP was referred to the appropriate licensing authority for investigation.

The meeting adjourned at 4:40 p.m.

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Amanda J. Diehl, Deputy Executive Director